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Supreme Court, U.S.
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No. 07-969

In The
Supreme Court of the United States

PAUL J. MEYERS, M.D.,
Petitioner,

v.

RIVERSIDE HOSPITAL, T/A RIVERSIDE REGIONAL MEDICAL CENTER; RUDOLPH FREEMAN, JR., M.D.; RICHARD HOEFER, M.D.; CHARLES FAULK, M.D.; BRUCE KAUDER, M.D.; AND PAUL REIN, M.D.
Respondents.

On Petition for Writ of Certiorari to the Supreme Court of Virginia

PETITIONER'S REPLY BRIEF

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I. MANY AVERMENTS IN RESPONDENT'S STATEMENT OF FACTS ARE IRRELEVANT, MISLEADING OR UNTRUE.

Events that occurred after July 25, 2000, the date on which the MEC recommended revoking all of Meyers' privileges, Br. in Op. at 10, 14-19, have no relevance to the reasonableness of that action or of Riverside's investigation. *See Singh v. Blue Cross / Blue Shield of Massachusetts, Inc.*, 308 F.3d 25, 32 (1st Cir.) (citing H.R. Rep. No. 99-903 at 10 *reprinted in* 1986 U.S.C.C.A.N. 6384, 6393) (reasonableness of peer review action judged by what was know when action was taken). The two expert reports excerpted at Appendix D1-E1, for example, were obtained five or more months after the MEC's recommendation to revoke Meyers' privileges, and were not presented to any peer review committee.[1] Appendix H (recently submitted in opposition to a motion for appeal costs) is not before the Court at all.

Nothing related to Meyers' proctorship is relevant to any issue in this petition and the representations about it, Br. in Op. at, 14-18, are inaccurate and

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[1] Riverside and Mary Immaculate Hospital (MIH) swapped expert reports in February, 2001. Riverside obtained Pritzker's report through a commercial broker, doctorquality.com, after learning of Levinson's reprimand by the California State Medical Board. A different covering letter, dated October 9, 2000, and not Appendix D1-D2, was provided to MIH peer review committees and to Riverside.

misleading. App. 1 at 1a-7a.[2] Equally irrelevant is Brandi Penny's law suit, and reference to it violates a court order incorporating an agreement that Riverside would not use the settlement in its litigation with Meyers. App. 2 at 8a-11a.

Riverside's averments about the Penny case, which Riverside's own expert opined involved no malpractice, App. 4 at 16a, are highly misleading.[3] A member of the ad hoc committee (AHC) that investigated Meyers following the March, 2000 suspension performed the temporary colostomy and had no criticisms of Meyers at the time the complication occurred. App. 5 at 23a.[4]

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[2] Meyers purported contradictions about proctorships, Br. in Op. at 18, are illusory because the cited paragraphs, 155 & 258, refer to different proctorships. Although Riverside ostensibly imposed the second proctorship because Meyers had not operated for 15 months, the MEC is still insisting that Meyers be proctored notwithstanding that he had been operating for several years at another hospital. App. 1 at 1a, ¶ 2 .

[3] The perforation did not occur until after surgery and was promptly recognized. App. 3 at 12a, ¶ 4. Levinson had no specific criticisms of this case, and was critical of the surgeon who performed the colostomy. App. 4 at 14a-16a. Meyers only settled the case because he lost his medical malpractice insurance after Riverside's insurer declared bankruptcy and Riverside refused to defend him. Meyers has had no other settlements or judgments in 16 years of treating mostly indigent patients with complex surgical problems. App. 3 at 12a, ¶ 2.

[4] Riverside defended Dr. Barry Gross, M.D., an Ob-Gyn and Vice President in charge of Riverside Physician's Associates, against a suit by a patient he sent home with a hole in her rectum and who developed near fatal septicemia. Third Am. Mot. for J. at ¶ 26-28.

The averments purporting to rebut statements germane to Meyers' claim that Riverside did not conduct a reasonable investigation are all untrue or rebut a straw man.[5] It is not true that the AHC reviewed any documents related to peer review actions in 1995, Br. in Op. at 11. App. 7 at 28a-29a. These were not even peer review actions. *See* 42 U.S.C. § 11151(9).[6]

This case was not even reviewed, illustrating that Riverside's actions are governed not by outcomes and their causes, but by the person involved. (Gross lost a jury verdict).

[5] Meyers never claimed that the AHC "relied exclusively on the report of an external reviewer", meaning that it relied on nothing else. Br. in Op. at 11. Meyers contended that the AHC relied exclusively on Levinson's report for its information about the cases on which Meyers' suspension was based, Pet. at 9, ¶ 2, and which is true, App. 6 at 24a-25a.

[6] They were letters reprimanding Meyers for ostensibly exceeding the scope of his privileges by performing laparoscopic appendectomies and repairing a suburethral diverticulum. The former hinged on the definition of "incidental", the latter was completely untrue. App. 8 at 30a. The AHC was informed of these actions by Defendant Freeman, Vice President of Medical Affairs, during a presentation he made to the committee about Meyers. App. 9 at 31a-32a. Freeman knew these 'actions' involved only credentialing issues, *id.* at 31a, but he misrepresented them as having involved quality of care concerns, App. 7 at 27a. (This was one of a number of false, defamatory statements that were made, contrary to the trial court's finding on which Riverside relies in part to vindicate the award of attorney's fees, Br. in Op. at 40-41, with knowledge of falsity and not reckless disregard of the truth.)

Riverside's claim that Levinson did not withdraw most of his criticisms, Br. in Op. at 11, is also untrue. Levinson withdrew his criticisms outright in four cases, Pet. at 45a; App. 4 at 17a, 18a, 21a; conceded that his critical statements about two other cases were not true, *id.* at 18a (p237), 20a (p253); and revised his criticisms in two more cases to "mildly" or not "overly" critical, *id.* at 18a, 21a, and conceded that his mild criticism of one of these cases was based on his personal preference, which was at variance with that of most gynecologists, *id.* at 19a.

Riverside's contention that two other reviewers agreed with Levinson, Br. in Op. at 11, is untrue. Partridge and Levinson criticized different cases and agreed in their criticisms of only two cases, App. 10 at 34a-35a (one of which they criticized for different reasons).[7]

The AHC did interview Meyers, Br. in Op. at 11, and Meyers did not claim otherwise, Pet. at 9, ¶ 2, but the committee's failure to question Meyers about the cases on which the 2000 suspension was based, App.

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[7] Partridge stated in his October 9, 2000 letter

> I did not see any indication that Dr. Meyers should not have privileges to perform open laparotomy cases...vulvar cases, cervical cases, and procedures on the vaginal wall such as colporrhaphies.

Pritzker lauded Meyers' removal of large uteruses vaginally as "admirable". These reports further undermine the reasonableness of the MEC's recommendation to revoke Meyers' non-endoscopic privileges.

7 at 28a, or the cases on which his 1999 suspension/proctorship were based, *Id.*, is further evidence that its investigation was unreasonable because no meaningful information was sought at the interview.

II. THE SPLIT AMONG THE CIRCUITS IS MATERIAL AND SHOULD BE RESOLVED.

Riverside's "threshold issue", Br. in Op. at 19-28, concerns what it means to say that summary judgment "is a question of law for the court to decide whenever the record is sufficiently developed". *See e.g. Meyer v. Sunrise Hosp.*, 22 P.3d 1142, 1149 (Nev. 2001) (citation omitted). This or equivalent language means that the court determines whether the requirements for summary judgment contained in the forum's procedural law have been met. *See Manzetti v. Mercy Hosp. of Pittsburgh*, 776 A.2d 938, 944-46 (2001). This determination, like the construction of any statute, is a question of law. *Id.* at 944. But what the court determines is whether there are any *genuine* disputes about *material* facts,[8] and if there are not, whether the substantive law entitles the moving party to a judgment based on the undisputed facts. *See e.g.* Fed. R. Civ. P. 56(c). The trial court does decide as part of this determination what is reasonable within the meaning of § 11112(a) - or at least, whether it does or not, is the question Meyers is asking this Court to decide.

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[8] The substantive law determines what facts are material and what disputes are genuine. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).

Who decides what is reasonable under§ 11112(a) decides what facts, and inferences from facts, are material, *Anderson*, 477 U.S. at 248, which in turn affects the evidence a physician may present to defeat the presumption of immunity. This is not "much ado about nothing". Br. in Op. at 23. Nor is the split among the circuits semantic.

Under Eleventh Circuit law, the trial court decides what is reasonable under § 11112(a), and, hence, what disputes over facts and inferences are material; juries decide only "subsidiary issues". *Bryan v. James E. Holmes Regional Medical Center*, 33 F.3d 1318, 1333-34 (11th Cir. 1994), *cert. denied* 514 U.S. 1019 (1995). For example, had Riverside disputed whether the AHC reviewed any medical records, the jury would be permitted to resolve the dispute, but not whether failure to review medical records is reasonable within the meaning of § 11112(a)(2); the court would decide that question. Before any subsidiary issue would be submitted to a jury, the court will have already decided what is reasonable with respect to that issue, otherwise it could not know whether the dispute was material, and hence needed to be resolved by a jury.

By contrast, under First Circuit law,

> "[t]his jury involvement is not limited to disputes over subsidiary issues of fact. Rather, a jury could be asked to decide the ultimate issues of reasonableness set forth in the immunity statute".

See Singh, 308 F.3d at 34 (footnote omitted). This is a very different standard under which *genuine* disputes

over the reasonableness of peer review actions are jury questions. If reasonable minds could differ on whether Riverside's investigation was reasonable, the jury would decide whether it was or not. *Id.* at 36. Riverside's contention that the two standards are the same because Dr. Singh made invalid arguments to the First Circuit and could not create a *genuine* dispute over the reasonableness of Blue Cross's action, Br. in Op. at 24-25, is a non-sequitur.

III. THE TRIAL COURT DID NOT APPLY THE CORRECT STANDARD OF REVIEW.

Riverside has acknowledged that it urged the trial court to defer to its peer reviewers, and that the correct standard under 42 U.S.C. § 11112(a) is not deferential. Rep. at 28. The evidence it cites to prove that the court nonetheless applied the correct, objective reasonableness standard, does not support the proposition for which Riverside cited it.[9]

Riverside also explains that by deference it was merely "implor[ing] the trial court...not to substitute [its] view of a reasonable peer review action from the perspective of the actual peer reviewers" (sic), and that this request "flowed from congressional intent and common law". Br. in Op. at 28-29. But congressional

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[9] Riverside cited the following: that the court permitted Meyers "to amend his action three times" (actually twice: the original complaint was nonsuited); that the court "examined the allegations and hundreds of exhibits that became part of the record"; and that whatever it "encouraged the court to do does not dictate what the court actually did". Br. in Op. at 28-31.

intent regarding deference is nowhere to be found in the language of HCQIA, and *Bryan* cannot be read to be creating federal common law to effect the purposes of HCQIA. Pet. at 22-23. It is also difficult to believe that this is what Riverside really meant by deference given that the court told the parties, "I think they did everything reasonably". Pet. at 51a.

That Riverside "implored the court to examine the allegations and to apply HCQIA's presumption of immunity", Rep. at 28, does not demonstrate that the court applied the correct standard to grant what amounts to summary judgment. Pet. at 13, n.8.[10] On the contrary, the fact that Riverside has consistently focused the courts' attention only on its own perspectives on its actions, and has never rebutted a single material fact or evidence Meyers has presented, proves that it urged the court to apply an incorrect, not a correct standard of review. *See Anderson*, 477 U.S. at 255 (court must accept non-movant's evidence unless rebutted). As its Statement of the Case ('Statement") demonstrates, these accounts have contained very little of relevance to the sufficiency of Meyers evidence, and have never, for example claimed

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[10] Virginia law disfavors summary judgment, *see Slone v. General Motors Corp.*, 457 S.E.2d 51, 52 (Va.1995) (citation omitted), and the presumption has no effect on that standard, or the quantum of evidence required to defeat summary judgment. *Singh*, 308 F.3d at 32-33. The presumption only relieved Riverside of its initial burden to produce evidence to support its contention "that there is no genuine issue of material fact on its compliance with the HCQIA standards". *See id* at 33.

- that it is not true that the documents on which the AHC relied contained fabrications, contrived criticisms, or false or misleading statements about Meyers or his cases;
- that the AHC did review medical records;
- that Levinson was not provided with incomplete medical records;
- that Bruder did not inform Freeman that there were many problems with Levinson's report;
- that Freeman did not refuse Bruder's request to review the medical records that had been sent to Freeman;
- that the AHC relied for information about Meyers' complication rates on invalid and inaccurate statements contained in an external reviewer's report (Cooper's);
- that Riverside's peer review actions never involved obstetrical or non-endoscopic cases.[11]

The legal relevance of the 1998/9 peer review actions to the present litigation on which Riverside has focused, Br. in Op. at 5-9, derives solely from the fact that Riverside has used the 1999 proctorship to justify the suspension of all of Meyers' privileges in March, 2000.[12] They have no relevance to what happened

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[11] This list does not exhausts Meyers' evidence that Riverside's investigation was unreasonable.

[12] Without these prior actions the five complications would not have justified the March, 2000 suspension. App. 5 at 22a-23a; App. 11 at 37a-38a. Meyers produced evidence to prove that the peer review actions in 1998/9 were unreasonable, and, therefore, that the 2000 suspension was unreasonable: suspension of Meyers' *laparoscopic* privileges was based on *hysteroscopic* case, App. 9 at

thereafter other than by confirming that these prior actions involved only endoscopic cases, they undermine rather than support the reasonableness of the MEC's recommendation to revoke Meyers' non-endoscopic privileges in July, 2000.

Yet, Riverside has made the hysteroscopic case on which Meyers' suspension in 1998 was based, App. 9 at 33a, the lynch-pin of its claim that it is entitled to immunity. Br. in Op. at 5-9. Riverside has recounted this patient's complication with varying color and accuracy to every court in every brief and at every hearing, and has never understood that even if its averments about this case were true, they could not invest it with immunity if its investigation after the March, 2000 suspension or the recommendation to revoke all Meyers' non-endoscopic privileges in July, 2000 were not reasonable under § 11112(a).

But they are not true. Riverside provided Cooper incomplete information about the hysteroscopic case.[13] Cooper was not made aware that the nurses made after the fact entries in the medical records without identifying them as such, Pet. at 53a, ¶ 3, and that the information was provided to Meyers at Meyers' request

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33a, and only Meyers' laparoscopic cases were proctored; cases were changed to justify suspension of Meyers' laparoscopic privileges, Pet. at 54a; attending physicians in private practice consulted Meyers about complex surgical cases while he was being proctored, App. 12 at 39a; Meyers was denied a hearing on the suspension.

[13] Riverside also provided Cooper with misleading information about Meyers' complication rates. Pet. at 10 n. 5.

after he stopped the procedure to assess the fluid deficit.

Cooper could not have had Meyers' operative report because in it Meyers described that he stopped operating to assess fluid balance, and estimated the fluid deficit to be approximately 1500 ccs. App. 13 at 40a.[14] Meyers may have underestimated the deficit, but he was not unconcerned about it or ignored it, as Cooper incorrectly assumed based on the information he was provided. Br. in Op. at Appendix A-2. Another physician grappling with the same systemic deficiencies six months earlier, estimated the deficit of his patient to be about 3000 milliliters. App. 14 at 41a. It was pure serendipity that Meyers' and not his patient developed bradycardia and asystole because their patients had very similar serum sodium concentrations. Third Am. mot. for J. at ¶ 120.

Because Riverside was more concerned with cost than quality, it did not purchase a closed-circuit fluid balance monitoring device for its facilities. Because it does not practice effective quality oversight, this systemic deficiency, Pet. at 55a, was not corrected after a serious case of fluid overload occurred six months before Meyers' hysteroscopic complication. The latent condition within the system , Pet. at 61a, ¶ 2,

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[14] Cooper also did not realize that the operative part of the procedure lasted only about one hour twenty minutes, not two hours, Br. in Op. at Appendix A-2, because Meyers first performed a diagnostic hysteroscopy to confirm the prior findings. (This was not Meyers' patient; the residents asked him to perform the procedure because it was technically difficult).

that caused the complication lay dormant waiting to entrap some unfortunate physician and his or her patients.

That physician happened to be Meyers. The career of an outstanding teacher and surgeon[15] has been destroyed, and federal law used to protect the actions that destroyed it. This case, and the questions it presents, evidence a compelling need for this Court to speak authoritatively on how trial judges, who will likely be interpreting HCQIA for the first time, should examine the record and decide what is reasonable within the meaning of this statute.

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[15] Even a member of the committee that investigated Meyers in 1998, acknowledged that Meyers "had very good technical ability [and]....was a good surgeon." App. 15 at 42a.

CONCLUSION

The writ of certiorari should be granted.

Respectfully submitted

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APPENDIX

APPENDIX 1

AFFIDAVIT OF PAUL J. MEYERS, M.D. (Dated Dec. 19, 2007)

Having been duly sworn, I, Paul J. Meyers, M.D., state the following:

* * *

2. The primary hospital where I perform most of my deliveries and surgery is Sentara-Careplex Hospital ("Careplex") in Hampton (formerly called Sentara Hampton General Hospital). I was originally granted privileges only in Obstetrics as a result of Riverside's action on my privileges. I was granted privileges to perform open gynecologic, vaginal procedures, and laparoscopic tubal ligations on or about April 1, 2003; to perform laparoscopic procedures on or about January 1, 2004. I was reappointed to the medical staff of the Careplex with full privileges on or about January 1, 2005. On or about January 1, 2006, I was appointed Director of Women's Health at the Careplex and I represent the Ob-Gyn department on the Careplex Hospital's Peer Review Committee.

3. I described the events surrounding the proctorship of my gynecological surgical cases at Riverside in an affidavit I executed on June 6, 2005, attached hereto as **Exhibit 1.** I affirm and incorporate the statements contained in that affidavit herein.

4. Dr. John Paulson joined the Riverside faculty in or around July 1, 2002. After Riverside refused to approve Dr. Morrison as a proctor, notwithstanding that he had become board certified, Dr. Paulson agreed to proctor my case and was approved as a proctor in May 2005. However, Dr. Paulson left Riverside due to conflict with administration, again leaving me without a proctor.

5. On or about November 1, 2006, I met with Chris Stolle, the Vice President for Medical Affairs, regarding my re-appointment to the Riverside medical staff. * * * I informed Dr. Stolle that I had previously requested that the faculty serve as proctors, and had been declined both by Dr. David Rayl, who was the residency director in 2002, and subsequently by Dr. Jewell Barnett who is still the current director. * * *

* * *

7. On or about February 21, 2007, I received a letter from Riverside, informing me that Riverside had unilaterally altered the conditions of the proctorship, in that it needed to be completed within 90 days from the date of the letter (approximately January 21, 2007). At the time, Dr. Paulson had already submitted a letter resigning his privileges at Riverside, and therefore Riverside knew that I was without a proctor.

8. * * * Dr. John Hyde, is a gynecologic oncologist with extensive experience with level IV laparoscopic procedures who was hired by Virginia Oncology approximately 6 months before Riverside's Ob-Gyn Residency Program was placed on probation. * * * I asked Dr. Hyde to act as my proctor, and he agreed.

9. The Riverside Medical Executive Committee met on or about April 11, 2007, and did not approve any of the suggested proctors, as it claimed that I would not be able to complete the proctorship in time even if it did approve a proctor. In addition, it did not provide an extension to the previously imposed deadline.

* * *

[Exhibit 1]

AFFIDAVIT OF PAUL J. MEYERS, MD.
(Dated June 6, 2005)

* * *

3.

In my efforts to secure a proctor for endoscopic cases, I first contacted Dr. David Bersinger, then Chairman of the Department of Obstetrics and Gynecology. He was unable to act as a proctor himself but recommended that I ask the OB/GYN teaching faculty at RRMC if they were willing to act in that capacity. * * *

4.

Pursuant to Dr. Bersinger's suggestion, I contacted Dr. David Rayl, then Residency Director of the Department of OB/GYN at RRMC, and asked if he and/or any members of the teaching faculty would be willing to act as my proctors and offered in exchange to give lectures to the residents as I had done over

many years while I was a member of the full time teaching faculty. * * *

Dr. Rayl informed me that he and his faculty neither had the time nor the expertise to act as my proctors. * * *

6.

I next contacted the Chairmen of all academic departments in the state of Virginia, to solicit their assistance to no avail. * * *

7.

Finally, I asked if Drs. Douglas Thom and Timothy O'Connell, who are partners of my wife, if they would be willing to act as my proctors. Riverside agreed to permit them to act in this capacity and they signed an agreement on March 14, 2002.

8.

During the period of February through March, 2002, I interviewed for and received a letter of intent for a position as a staff obstetrician gynecologist at the Peninsula Institute for Community Health ("PICH"). PICH is a non profit organization receiving federal grant money to provide medical services to indigent patients in federally designated underserved areas of Newport News and Hampton. The credentialing process for that position took another six months, and I was not able to see patients at PICH until I was credentialed both at PICH and Sentara Hampton

General Hospital ("SHGH"), sometime in the middle of September 2002.

9.

The majority of patients at PICH are uninsured. Those that have insurance are insured through the Medicaid program. In Virginia Medicaid is administered through private HMOs. The vast majority of PICH Medicaid patients belong to the Sentara HMO and are required to receive care within the Sentara system. Only a small fraction of PICH patients have the Medicaid HMO – Healthkeepers – that is accepted at RRMC.

10.

In addition, Riverside has a standing policy of requiring uninsured patients to pay 80% of their estimated costs in advance. *See* **Ex. 5.** Representative charges for a vaginal hysterectomy, abdominal hysterectomy and laparoscopy at Riverside all exceed $8500. *See* **Ex 6**.

11.

Few if any uninsured PICH patients are able to have elective surgery at RRMC. Therefore, only a very small fraction of my patients can realistically have surgery at RRMC.

12.

In November and December 2003, shortly after I was in a position to admit any patients to RRMC, Drs.

Thom and O'Connell both declined to continue acting as my proctors. I have discussed the reasons for this change of heart personally with both Drs. Thom and O'Connell. Contrary to what RRMC has represented to another judicial officer in another forum that I attended, the unwillingness of Drs. Thom and O'Connell to continue to act as my proctors had nothing to do with quality of care issue connected with me or my surgery or my cases.

13.

At the end of December 2003, I met with Drs. Freeman and Barnett at RRMC's request to discuss my proctorship situation. Several proctors were discussed at that time, one of them, Dr. Jeffrey Morrison. The only objection raised was that he was not yet board certified and also was not a full time member of the RRMC medical staff. Dr. Morrison recently became board certified, and is now a member of the RRMC full time medical staff. Nonetheless, I was notified by Dr. Freeman that Dr. James Mullins, new Chairman of OB/GYN at RRMC, refused to approve Dr. Morrison as my proctor ostensibly because he would not be willing to tell me when to stop. Ex. 7

14.

During the entire period, 1998-2000, that my laparoscopic cases were investigated, I was never informed as to what specific laparoscopic operation I should have abandoned. I was merely informed that in the opinion of some obstetrician-gynecologists at Riverside I should not have attempted to perform laparoscopic surgery in less than five cases because in

their opinion the circumstances presented contraindications to laparoscopic surgery. These circumstances were:

(1) a uterus weighing 1100 grams;

(2) a patient who had a pelvic abscess;

(3) a patient who required several procedures to correct recurrent prolapse that lasted about 8 hours but who had an otherwise uneventful procedure sustained no complications;

(4) on patient who was admitted with subacute bowel obstruction on the medical service, and whose diagnosis was uncertain.

15.

Since the medical literature does not, to my knowledge, indicate that any of these situations are contraindications to laparoscopic surgery, and I am aware of several articles indicating that these types of cases are managed laparoscopically at other centers, I disagree with my colleagues. None of my critics have ever provided me with any medical literature to support their opinions, and, therefore, they have not persuaded me of the correctness of their opinions.

* * *

APPENDIX 2

CIRCUIT COURT FOR THE CITY OF NEWPORT NEWS, VIRGINIA

No. CL 02-31614W-01

[Dated April 21, 2006]

BRANDI M. PENNY,
Plaintiff,

v.

PAUL J. MEYERS, M.D. and RIVERSIDE HOSPITAL, INC.,
Defendants.

ORDER

This matter came before the Court on the Motion of the Plaintiff ("Penny") to dismiss with prejudice her action against the Defendants in this matter, and on the Motion of Defendant Paul J. Meyers ("Dr. Meyers") to incorporate by reference herein the terms of the Release executed by the parties, and to file said Release under seal.

It appearing to the Court from the endorsement of all parties to the action that no opposition exists to the

relief requested by Penny or requested by Dr. Meyers, it is hereby:

ADJUDGED, ORDERED, and DECREED that the terms of the Release executed by the parties are incorporated into this Order. It is further:

ADJUDGED, ORDERED, and DECREED that the Release executed by the parties will be filed under seal and shall be opened only pursuant to the written agreement of Dr. Meyers and Riverside Hospital, Inc., or further order of the Court. It is further:

ADJUDGED, ORDERED, and DECREED that the action is dismissed with prejudice.

The Clerk is directed to provide a certified copy of this Order to all counsel of record following entry.

THIS CAUSE IS ENDED.

ENTER: April 21, 2006

/s/
Judge

I ASK FOR THIS:

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Counsel for Dr. Meyers

WITNESS the following signature and seal this 21st day of December, 2005.

/s/
Brandi M. Penny

STATE OF VIRGINIA,
City/County of Richmond, to wit,

This day came Brandi M. Penny, whose name is signed to the foregoing writing bearing the date of the 21st day December, 2005, and has this day acknowledged the same before me in the jurisdiction aforesaid.

Given under my hand this 21st day of December, 2005.

My commission expires: 9/30/2006

/s/
Notary Public

LIMITED RELEASE AS BETWEEN DR. MEYERS AND RIVERSIDE

In furtherance of this Release, and in addition to the foregoing terms, the undersigned further agree, promise and covenant as follows:

1) The parties agree to not disclose or use the settlement in currently pending litigation commenced by Dr. Meyers against Riverside, namely, Newport News Circuit Court, Law No. 31394-EH. The parties understand and agree that this Release does not preclude reporting to the National Practitioner Data Bank or disclosure otherwise provided by law or regulation.

* * *

APPENDIX 3

July 6, 2000

To: Whom It May Concern
Re: Review of records
Paul J. Meyers, M.D.

The following is based on a review of 31 cases seen by Paul J. Meyers from 11/12/99 through 3/1/00.

This group of patients appears to have more pathology than an average group of patients. They appear at higher risk than patients seen in an average gynecologic practice do. This group is compatible with patients referred to a teaching center with complex problems.

The complications in this group are recognized complications of surgery. The risk of complications in patients with complex problems is higher than that in average patients. The risk of complications at laparoscopy is highest for complex surgery, intermediate for sterilization and least for diagnostic laparoscopy. However the risk would be greater at laparotomy than laparoscopy. The risks do not outweigh the potential benefits in Dr. Meyers' patients.

The post-operative care of these patients was diligent and appropriate. The complications were promptly recognized and treated.

Overall, Dr. Meyers appears to have acted reasonably in planning procedures, performing surgery and managing the patients post-operatively.

Sincerely yours,

/s/
Dan C. Martin, M.D.

APPENDIX 4

DEPOSITION OF CARL J. LEVINSON
May 19, 2003

* * *

[p.165]

* * *

Q. So am I right in thinking your criticism is mostly of the second surgery where you believe it should have just been drained?

A. Yes. Well, I do have some criticism of the first one in that there was a complication. * * *

* * *

Q. You're not saying that the first laparoscopic surgery was unindicated, are you?

A. No, it was indicated.

Q. You're not saying it shouldn't have been done laparoscopically, are you?

A. No.

Q. You're not saying that what was done shouldn't have been done, are you?

A. No.

[p.166]

Q. So the complication that resulted from what was done, are you saying he must have done something wrong to have had that complication or - - I'm not quite sure.

A. No, but you are parsing each individual case.
* * *

* * *

[p.167]

Q. So you're critical of the second operation?

A. Very.

Q. Very critical. * * * Are you saying that - - * * * that if you just reviewed this one case, you wouldn't have any criticism, but given that there were these other cases, you were wondering - -

A. Exactly.

Q. - - whether this guy was up to it.

A. Exactly right.

Q. Am I correct about that?

A. Yes.

* * *

[p. 168]

* * *

A. If you had given me this case alone, separate and distinct from any knowledge between this and another case, I would have said that's a known injury with laparoscopy.

* * *

[p. 169]

A. * * * If I had been asked to review this case as a malpractice case, I would have said, "No."

Q. "No" what?

A. No, there's - -

Q. No deviation from standard?

A. - - there's not malpractice.

* * *

[p. 170]

* * *

Q. * * * you were wondering whether he was not biting off more than he could chew because there were all these other complications?

A. (Nodding in the affirmative.)

* * *

[p. 214]

* * *

Q. * * * If that's true, would you have any criticisms of Dr. Meyers if he had a report from an ultrasonographer showing, quote, left ovary is enlarged - -

A. No, I would have no objection on the basis of that other generated ultrasound.

* * *

[p. 230]

* * *

Q. And had you known that that was a postoperative value, presumably you would have not made the criticisms that you made; am I correct about that?

A. That's correct.

Q. And even less would you have made your criticism if you had known that this patient came into the hospital on the 27th of December complaining of acute onset of abdominal pain. Correct?

A. I would have no objection to an immediate laparoscopy.

* * *

[p.237]

* * *

Q. Uh-huh. What else does it say?

A. "It was also noted that the left adnexa and uterus had been previously removed."

Q. So it's not actually true that they didn't describe it, is it?

A. It's tucked away in there.

* * *

[p.238]

* * *

Q. So if the doctor had given the description you have read for us into the record and had taken a picture of the cyst and put it in the medical record, you wouldn't be critical of him, would you?

A. Well, a 4-centimeter simple cyst is not pathology.

Q. So you would be critical?

A. I would be mildly critical.

Q. Let me ask you this: Supposing you laparoscoped a patient because of pain and you found a simple cyst, would you just leave that cyst alone?

A. Probably.

Q. You would?

A. I would.

Q. And is that what the majority of your peers do in a 37-year-old woman?

A. Probably not. I tend to be on the slightly conservative side.

* * *

[p. 240]

* * *

Q. * * * - - I just want you to summarize your criticism for me.

A. I don't know whether there was a preoperative medical clearance on this patient. It struck me that she should have had one.

Q. Do you say that in your report here?

[p. 241]

A. Yes.

Q. Where?

A. She had certain risk factors.

Q. Where does it say she should have had a pre-op clearance, but didn't have one?

A. I shouldn't have to say that.

Q. Oh, okay. That's a criticism you're making now?

A. If she has risk factors, then something should have been done about that.

Q. So you're making that criticism now?

A. Yes.

* * *

[p.253]

Q. Tell me what organ was struck to create a hematoma in the anterior abdominal wall, Doctor.

A. I made a wrong assumption as to where it was and how it was developed.

* * *

[p.288]

* * *

Q. But it's fair to say you're not overly critical of this case?

A. No.

MR. HARRIS: That's correct? Is that correct?

THE WITNESS: That's correct.

* * *

[p.295]

* * *

Q. * * * But if that were true, would you fault him for removing the appendix?

A. In the absence of an abscess and covered by antibiotics, no - -

* * *

APPENDIX 5

Deposition of ERIC M. BASHKOFF, M.D.
June 8, 2005
1:25 p.m.

* * *

[p.8]

* * *

A. Dr. Freeman spent a lot of time defining what the problem was because, at least I can speak for myself, I wasn't aware of all the things that had happened before with the previous peer reviews and evaluations, and so forth. I wasn't privy to any of that information before our meetings.

Q. Okay.

A. So Dr. Freeman, I remember him spending a good deal of time just trying to lay out the groundwork for the case. * * *

[p.119]

* * *

Q. Would I be correct in characterizing your opinion then, that the whole is greater than the sum of its parts?

A. Yes --

MR. HARRIS: That's been asked and answered.

THE WITNESS: - - absolutely. I think that is a very fair statement, Gestalt, which is why I think it's useless to pick at each individual case and try to turn over each individual case and try to justify its legitimacy in one sense or another. You know, the fact that while one case was okay on patient selection, but wasn't okay on complications, one case had a different - - if you take each case individually, sure. The Brandy Penny case, that didn't bother me. I wouldn't have made any conclusion that the, you know, any action should have

[p.120]

been taken against Dr. Meyers based upon my knowledge of that one case but - -

* * *

THE WITNESS: What I'm saying is that it's the sum total of all of the information that we were presented, that yes, it does have an impact greater than the sum of its parts.

* * *

APPENDIX 6

[p.13]

* * *

STEWART WETCHLER, M.D.,
called as a witness, having been first duly sworn,
was examined and testified as follows:

* * *

[p.129]

* * *

DR. SMITH: * * * Is that questionable judgment regarding case selection based on the experience of other - - let's say based on the consensus of the other gynecologists?

THE WITNESS: No. I mean, that was exactly why we deferred to the expert. I think you understand that we used what we know combined with the expert's report because it can only be evaluated by someone who does all the same procedures. And since I do not and the other people on the committee did not, that's why we deferred to the experts. So just because Dr. Meyers does a procedure through the laparoscope that other people in the

[p.130]

department don't do, does not make it wrong. That's why we have to - - and my memories of the literature, though I did not do a specific search for this, were that you couldn't find an objective standard to go by. That's why we deferred to an expert.

* * * And we knew that we didn't know, and we knew that we didn't feel capable of evaluating the procedures ourselves and we were not given the full charts to look through, didn't look through the full charts that I recall. But we knew we needed someone who did the procedures to evaluate it.

DR. SMITH: Would you summarize this by saying that your criticism of Dr. Meyers' case selection is based solely on the Levinson report?

THE WITNESS: Primarily. * * *

* * *

[p.139]

DR. SENEY: I think so.

HEARING OFFICER CARPENTER: Dr. Wetchler, I have one question and this kind of follows up on Dr. Seney's question. If I go out and I get 15 Ob-Gyns who do surgery, am I likely to see a divergence in opinions in that group of 15 Ob-Gyns on how much is too much in laparoscopic work?

THE WITNESS: Absolutely.

HEARING OFFICER CARPENTER: And given those same 15 Ob-Gyns, is it also likely that I would be more likely to have people favor laparoscopy in sort of direct proportion to their ability with the instrument? In that same group of 15, if we had a laparoscopic ace and we had somebody - -

THE WITNESS: Absolutely, that's possible. * * *

HEARING OFFICER CARPENTER: Thank you, Doctor.

DR. KADAR: Two questions. You said that you wanted Levinson to evaluate this because you wanted

[p.140]

somebody who was doing these procedures. Are you making the assumption that Levinson does laparoscopic resetion of rectal endometriosis, prolapse surgery? Do you know that for a fact?

THE WITNESS: I don't know that for a fact.

* * *

APPENDIX 7

Deposition of:
STEVEN E. MARKS
October 28, 2005
9:33 a.m.

* * *

[p.81]

* * *

BY DR. KADAR:

Q. All right. Prior to the 1999 action, * * * - - it's your understanding there was a prior investigation into quality of care issues; is that correct?

A. That was my understanding.

Q. Do you recall reviewing a report on that investigation?

A. I don't recall.

Q. And if there is no report from those prior years whenever they were listed in Exhibit A of your report, then you wouldn't have reviewed it; is that correct?

A. I believe that's correct.

* * *

[p.112]

* * *

Q. And also you didn't actually question him about any specific cases, did you?

MR. HARRIS: You mean that he personally or the Committee?

DR. KADAR: Either.

THE WITNESS: No, I don't believe so.

[p.113]

BY DR. KADAR:

Q. * * * Doctor, you didn't question him either about the 1998 cases, 1998-1999 cases?

A. No, we did not.

Q. And you didn't inquire about the nature of the investigations in '95?

A. No, we didn't ask him about any specific cases in 1995.

Q. Not only specific cases, but you didn't ask him about the nature of those investigations, did you?

A. No, we did not.

* * *

APPENDIX 8

EXAMINATION UNDER TRIAL of THOMAS L. HANNA, M.D., held on January 20, 2005

* * *

[p.79]

* * *

Q. And repair of a suburethral diverticulum, would Dr. Meyers be allowed to perform that procedure?

A. Yes.

* * *

APPENDIX 9

The deposition of RUDOLPH FREEMAN, M.D., a Witness, commencing on October 27, 2005

* * *

[p.8]

* * *

Q. Okay. And F-6 is a history of the corrective actions. The same thing, you would have drafted that, did you?

A. Correct.

[p.9]

Q. And you did an overhead presentation?

A. That would probably be the same context, same time frame as that, so the answer would be yes.

* * *

[p.15]

* * *

Q. You weren't actually involved in the prior credentialing issues that came up in '95 and '96 with Dr. Meyers, were you?

A. I would have almost certainly been involved in the '96 incident only because I would have been the vice president of the medical staff that year. * * *

* * *

[p.18]

* * *

Q. But doctor, you summarized for the ad hoc committee there were actions in April of '95 and June of 1995.

A. And that's just a matter of looking at the credentials file. * * *

Q. * * * - - my question is quite simply, is that the actions that took place in 1995 and 1996 were credentialing issues.

A. That's correct.

* * *

[p.19]

* * *

Q. Okay. That was my question. So you knew there were no complications involved?

MR. HARRIS : Objection to the form.

THE WITNESS: I was not aware of any other matters other than credentialing matters in 1995 and 1996.

* * *

[p.72]

* * *

THE WITNESS: It is my recollection that the suspension was based on the complications that occurred to Ms. Artis.

* * *

[p.73]

* * *

Now, just for the record, Sabrina Artis was a hysteroscopic case, correct?

A. Correct.

* * *

APPENDIX 10

MEMORANDUM

TO: MEDICAL STAFF CREDENTIALS COMMITTEE
FROM: JAMES M. MULLINS III, M.D., CHAIR, OB/GYN
DATE: 3/4/01
RE: PAUL MEYERS, M.D.

* * *

It is apparent from a review of Dr. Meyers' laparoscopic case log, in which he notes participation in 664 laparoscopic procedures, that he has a breadth of experience. His overall complication rate of 1.9% is lower than most published complication rates. Even his complication rate of 8.5% (447 cases) from 1999-4/1/2000, during which 67% of his cases were "major" or "advanced" laparoscopic procedures, is consistent with previously published rates, and not significantly different from the laparoscopic complication rate of 4% at Mary Immaculate Hospital in 1999.

A review of the evaluations by Drs. Partridge and Levinson, * * * serve only to demonstrate that there may be several different approaches to the same gynecologic problem(s). Drs. Partridge and Levinson,

however, agreed in the criticism of two laparoscopic procedures, * * *

APPENDIX 11

The discovery deposition of PAUL REIN, M.D., commencing on December 15, 2005

* * *

[p.8]

* * *

Q. * * * Talking about rates, whether it be transfusion rates, infection rates, complication rates, would you agree with me that rates fluctuate in the short term?

A. Absolutely.

* * *

[p.10]

* * *

Q. * * * Would you agree with me that, I'll phrase it one way and if it's not clear, you let me know, that random events can cluster?

MR. HARRIS: Objection to the form. Go ahead.

BY DR. KADAR:

Q. Do you understand my question?

A. Sure. Of course, of course they can cluster.

* * *

[p.23]

* * *

Q. * * * Would you agree with me that the complication rates of a procedure varies with the complexity of the operation?

A. I would agree with that.

Q. Would you agree with me that for a given operation, the complication varies depending on the difficulty of the case?

* * *

THE WITNESS: I agree with that.

* * *

[p.31]

* * *

THE WITNESS: That couldn't be more incorrect. No one is ever suspended over five cases. No one is ever suspended over five cases. * * *

[p.32]

* * *

BY DR. KADAR:

Q. So you agree with me that just because you have a run of five bowel complications in itself would not warrant summary suspension of a physician, correct?

* * *

THE WITNESS: It is terribly unfair on your part to pull five cases out of context. You have to look at the big picture.

* * *

APPENDIX 12

OB/GYN CHAIRMAN'S REPORT
PROCTORSHIP, PAUL MEYERS, M.D.
PROCTOR: WILLIAM J. MANN, M.D.
October 6, 1999

* * *

Summary

* * *

Dr. Mann * * * also noted that several attending physicians requested Dr. Meyers opinion as to the endoscopic management of specific private patients.

* * *

* * * Of the cases reviewed, six other attending physicians had asked him to assist with difficult procedures.

* * * I believe Dr. Meyers has uniformly fulfilled the terms of his proctorship. He is recognized within our own community as a skilled and competent surgeon.
* * *

Karen L. Bruder, M.D., FACOG
Chairman, Department of OB/GYN
Riverside Regional Medical Center

APPENDIX 13

OPERATIVE REPORT

PATIENT: * * * AGE: * * * MR#:
PHYSICIAN: * * * LOC: * * * DATE: 12/10/98

PAGE 2

PROCEDURE: * * * This had been accomplished by 10:50 a.m. At the time input and output was assessed; 9000 in and ~~50 to 100~~ 5300-plus out ~~and~~ in suction, ~~of~~ and 850 in the Foley. The fluid in the kick bucket on the floor was estimated to be 1500 cc, resulting in a fluid deficit of approximately 1500 cc. At that time the patient was hemodynamically stable, without evidence of pulmonary edema, hemodynamic or cardiac destabilization. * * *

APPENDIX 14

OPERATIVE REPORT

PATIENT: * * *	AGE: 48	MR#: 23-00-73
PHYSICIAN: * * *	LOC: DIS	DATE: 03/31/98

* * *

PROCEDURE: * * * We were unable to account completely for 3,000 cc of irrigation fluid. It was undoubtable that a good 1-2 liters of this were spilled on the floor and on the drapes, and on my gown. * * *

APPENDIX 15

Deposition of:
CHARLES FALK, M. D.
October 28, 2005

* * *

[p.77]

* * *

BY DR. KADAR:

Q. Now, do you have an opinion now of * * * of Dr. Meyers' technical ability as a surgeon? Do you have an opinion?

A. I always thought that Dr. Meyers had very good technical ability. I thought he was a good surgeon.

* * *